ScieniQ Publishers

Advance Medical and Clinical Research

Review Article

Happiness and Well-Being as Clinical and Public Health Outcomes *A Narrative Review and Eight-Pillar Integrative Framework for Prevention, Care and Hu man Flourishing*

Dr. Ignacio Bonasa Alzuria

Liderarte, Madrid, Spain

*Corresponding author
Dr. Ignacio Bonasa Alzuria Liderarte, Madrid, Spain

Received: 13 May 2026
Accepted: 17 May 2026
Published: 22 May 2026

Abstract

Background: Happiness and well-being have moved from the margins of philosophy and social policy into the centre of medical, clinical, occupational and public health research. A growing body of evidence links subjective well-being, life satisfaction, meaning, social connection and psychological flourishing with mental health, cardiovascular risk, healthy behaviours, resilience, health service quality, burnout prevention and recovery-oriented care. Yet clinical systems still tend to measure distress, impairment and disease more systematically than strengths, resources and flourishing.

Aim: This article synthesises contemporary evidence on happiness and well-being as clinically relevant outcomes and proposes an eight-pillar integrative framework that can be used for prevention, assessment, intervention design and evaluation across health care, workplaces and community settings.

Methods: A targeted narrative review was conducted across landmark theoretical contributions, measurement frameworks, systematic reviews, meta-analyses, clinical trials, public health reports and global policy documents published up to May 2026. The synthesis privileges medical relevance, translational usefulness, methodological transparency and applicability to whole-person care.

Results: The evidence supports a multidimensional understanding of well-being that includes hedonic, eudaimonic, relational, functional, physical, professional, financial and digital dimensions. Positive psychology interventions, mindfulness-based approaches, exercise, social connection, meaning-centred practices, sleep and lifestyle interventions, compassion training and organisational interventions show potential to improve well-being, although effect sizes vary and implementation quality remains decisive. In clinical contexts, well-being should be treated neither as a luxury nor as a replacement for diagnosis and treatment, but as a complementary outcome that strengthens prevention, adherence, recovery, workforce sustainability and patient-centred care.

Conclusion: Happiness and well-being deserve a rigorous place in medical and clinical research. The proposed eight-pillar framework offers a pragmatic bridge between subjective experience, clinical prevention and public health strategy. Future research should prioritise longitudinal designs, culturally sensitive measures, equity, implementation science and clinically meaningful endpoints.

Keywords: Happiness; well-being; flourishing; mental health promotion; positive psychology; lifestyle medicine; occupational health; burnout; whole-person care; public health

Table 1. Manuscript structure and editorial positioning

Element	Editorial value
Article type	Narrative review with an integrative clinical and public health framework.
Clinical relevance	Links happiness and well-being to prevention, mental health, chronic disease, occupational health and patient-centred care.
Methodological prudence	Avoids fabricated primary data and presents the framework as a translational proposal requiring prospective validation.
Original contribution	Integrates hedonic, eudaimonic and whole-person perspectives into an eight-pillar model applicable to clinical screening and interventions.
Submission readiness	Includes abstract, keywords, methods, limitations, declarations, tables, quality checklist and APA 7 references.

Introduction: why happiness now belongs in medical and clinical research

For much of the modern history of medicine, the dominant clinical question was whether disease could be diagnosed, treated, controlled or prevented. That question remains indispensable, but it is no longer sufficient. Patients, professionals and health systems increasingly ask a second question: not only whether people survive, but whether they live with vitality, meaning, social connection, functional capacity and hope. This shift does not dilute the scientific mission of medicine; it expands it toward the complete human being. The World Health Organization has long defined health as more than the absence of disease, and contemporary WHO documents describe mental health as a state of mental well-being that enables people to cope with stress, realise abilities, learn, work and contribute to community life [1,2].

The clinical relevance of happiness is often misunderstood because the term can sound superficial. In research, however, happiness usually refers to subjective well-being: affective balance, life satisfaction and evaluative judgements about life as a whole [3,4]. Well-being extends beyond pleasant emotion to include purpose, autonomy, mastery, positive relationships, self-acceptance, engagement, contribution and flourishing [5-8]. These dimensions are not merely moral ideals. They interact with stress physiology, health behaviours, social support, immune regulation, treatment adherence, resilience, occupational functioning and mortality risk [9-11].

The urgency is amplified by the global mental health burden. Mental health conditions affect over a billion people globally, and WHO stresses the need to reshape environments, strengthen community-based care and embed prevention across sectors [2]. Workplaces have become a particularly important arena. The WHO guidelines on mental health at work identify organisational interventions, manager training, worker training, individual interventions and return-to-work strategies as evidence-based routes for promoting mental health and enabling participation [12]. Health care itself is not immune: burnout, moral injury, administrative burden and workforce shortages threaten both professionals and patients [13-15].

A medical article on happiness and well-being must therefore avoid two errors. The first is romantic reductionism: pretending that gratitude exercises, optimism or positive emotion can replace structural reform, clinical treatment or social protection. The second is biomedical narrowness: ignoring subjective well-being because it is harder to measure than blood pressure or C-reactive protein. Rigorous clinical research should hold both truths together. Happiness is not a magic cure; it is a measurable, modifiable and clinically meaningful resource that can complement prevention, treatment and recovery.

This article proposes an eight-pillar integrative framework that translates evidence from positive psychology, public health, lifestyle medicine, occupational health and whole-person care into a practical model. The model is not offered as a finished clinical protocol, but as a structured architecture for assessment, intervention design and research. Its eight domains are body, thought, emotions, transcendence or meaning, social life, professional life, financial life and technology. Together they describe the ecology in which happiness and well-being are created, damaged, restored and sustained.

Conceptual foundations: from happiness to flourishing

The first requirement for scientific credibility is conceptual precision. Happiness, subjective well-being, psychological well-being, quality of life and flourishing are related but not identical constructs. Subjective well-being is generally understood as a combination of life satisfaction, frequent positive affect and infrequent negative affect [4,16]. Psychological well-being highlights the deeper architecture of human functioning: autonomy, environmental mastery, personal growth, positive relations, purpose in life and self-acceptance [6,17]. Social well-being expands the lens to integration, contribution, coherence, actualisation and acceptance of society [5,18]. Flourishing then offers a broad multidimensional construct that can include happiness, mental and physical health, meaning and purpose, character, close social relationships and financial/material stability [8,19].

In clinical terms, the distinction matters. A person can be free from major depressive symptoms but still feel empty, disconnected and purposeless. Another person can live with chronic illness while experiencing meaning, loving relationships and high subjective well-being. The dual-continua model of mental health helps explain why mental illness and positive mental health should be measured separately rather than assumed to be opposite poles of one scale [5,20]. This perspective is vital for prevention because the absence of pathology does not automatically imply the presence of resilience, purpose, hope or healthy social functioning.

Hedonic and eudaimonic traditions are sometimes presented as rivals, but clinical practice benefits from integrating them. Hedonia focuses on pleasure, comfort, positive affect and satisfaction. Eudaimonia emphasises meaning, virtue, self-realisation, contribution and living in accordance with valued goals [21,22]. A patient recovering from burnout may need hedonic restoration, such as sleep, enjoyment and relief from overload; but may also need eudaimonic reconstruction, such as purpose, boundaries, identity, moral repair and contribution. A healthy model must include both the warmth of feeling better and the depth of living better.

The PERMA model popularised a five-domain language for well-being: positive emotion, engagement, relationships, meaning and accomplishment [7]. Other models, including self-determination theory, emphasise autonomy, competence and relatedness as basic psychological needs [23,24]. Flow theory highlights absorption, challenge-skill balance and intrinsic reward [25]. These models provide complementary mechanisms rather than exclusive taxonomies. For medical research, their value lies in making well-being measurable, teachable and open to intervention.

The proposed eight-pillar framework therefore does not replace established models. It translates them into an applied clinical ecology. The body pillar addresses sleep, nutrition, movement, pain, energy and somatic regulation. The thought pillar addresses cognitive appraisal, beliefs, rumination, attention and psychological flexibility. The emotions pillar addresses emotional literacy, regulation, compassion and positive affect. The transcendence pillar addresses meaning, purpose, spirituality, values and legacy. The social pillar addresses connection, belonging, family, friendship and community. The professional pillar addresses work, vocation, autonomy, contribution and burnout prevention. The financial pillar addresses security, stress, dignity and freedom from destructive scarcity. The technological pillar addresses digital habits, attention, connection and the psychosocial effects of algorithmic environments.

Table 2. Conceptual distinctions for clinical use

Construct	Core meaning	Clinical use
Happiness / subjective well-being	Life satisfaction plus affective balance.	Useful for screening global life evaluation and emotional tone.
Psychological well-being	Autonomy, mastery, growth, purpose, relationships and self-acceptance.	Useful for eudaimonic functioning and recovery-oriented goals.

Flourishing	Whole-person thriving across happiness, health, meaning, relationships, character and material stability.	Useful for public health, whole-person care and longitudinal research.
Quality of life	Perceived functioning and satisfaction within health-related domains.	Useful in chronic disease, oncology, rehabilitation and patient-reported outcomes.
Resilience	Capacity to adapt, recover and grow after stress or adversity.	Useful in prevention, trauma, workforce sustainability and relapse prevention.

Why well-being is clinically relevant: mechanisms and outcomes

The association between well-being and health is supported by several plausible pathways. First, positive psychological states may buffer stress responses. Chronic stress is associated with allostatic load, inflammation, autonomic imbalance, sleep disruption and behavioural risk. Positive emotions can broaden attention, support adaptive coping and build psychological resources over time [26.27]. Although no single emotional state immunises a person against disease, repeated experiences of calm, gratitude, connection, hope and meaning may change the probability of healthier choices and more resilient recovery trajectories.

Second, well-being is linked to health behaviours. People who experience greater purpose, self-efficacy and life satisfaction are often more likely to engage in physical activity, maintain social relationships, sleep more consistently, adhere to treatment and avoid harmful behaviours [28,29]. This direction of causality is complex: better health can increase well-being, while higher well-being can support better health. The clinical implication is not to claim a simple causal chain, but to recognise well-being as part of a reciprocal system in which biology, behaviour, environment and meaning interact.

Third, social connection is one of the strongest bridges between happiness and health. Meta-analytic evidence has linked social relationships with reduced mortality risk, while loneliness and social isolation have been associated with poorer mental and physical outcomes [30,31]. The public health significance is now widely recognised, including by the U.S. Surgeon General's advisory on loneliness and social connection [32]. For clinicians, this means that a patient's social world is not background information; it is part of the therapeutic landscape.

Fourth, meaning and purpose may influence resilience and longevity. Purpose in life has been associated with reduced mortality and better functional outcomes in multiple studies [28,33]. Meaning-centred interventions in oncology and palliative care also illustrate the clinical importance of existential resources when cure is not possible or when suffering must be integrated into life rather than simply removed [34,35]. This is particularly important in chronic illness, grief, trauma and ageing.

Fifth, well-being is relevant to health systems because professionals' well-being affects care quality, safety, empathy, retention and organisational sustainability. Burnout among clinicians is not merely a private problem; it is a system-level risk. Evidence suggests that interventions to reduce burnout and improve well-being may include both individual and organisational components, but durable improvement requires attention to workload, autonomy, leadership, community and meaning in work [15,36,37].

Table 3. Mechanisms linking well-being with clinical outcomes

Pathway	Possible mechanism	Relevant outcomes
Stress buffering	Positive affect, meaning and support may reduce perceived stress and improve coping.	Anxiety, depression risk, sleep, allostatic load, recovery.
Health behaviours	Purpose and self-regulation can support activity, adherence, nutrition and sleep.	Chronic disease prevention, medication adherence, lifestyle risk.
Social connection	Belonging and support reduce loneliness and increase practical resources.	Mortality risk, depression, functional status, recovery.
Meaning reconstruction	Values and purpose help integrate suffering and sustain motivation.	Palliative care, oncology, trauma recovery, chronic illness adaptation.
Workplace sustainability	Autonomy, fairness, workload balance and recognition protect energy and engagement.	Burnout, retention, patient safety, empathy and productivity.

Methods: targeted narrative review and translational synthesis

This manuscript uses a targeted narrative review methodology. The purpose was not to perform a formal systematic review or meta-analysis, but to synthesise conceptually and clinically relevant evidence across several mature and emerging domains. Literature was selected from foundational theoretical works, measurement studies, systematic reviews, meta-analyses, randomised trials, global health reports and implementation-oriented publications. Priority was given to peer-reviewed sources and recognised institutional reports with relevance to medicine, mental health, occupational health and public health.

The synthesis considered literature up to May 2026, including recent contributions on well-being measurement, positive psychology interventions, workplace mental health, flourishing in medicine, whole-person care and digital well-being. The review included landmark works by Diener, Ryff, Keyes, Seligman, Ryan and Deci, Fredrickson and VanderWeele, along with contemporary evidence from systematic reviews and meta-analyses [38-41]. Public health orientation was informed by WHO frameworks on mental health and well-being [1,2,12,42], and by the World Happiness Report [43].

Selection criteria were pragmatic and translational. Included sources had to clarify definitions, provide measurement tools, examine links between well-being and health outcomes, evaluate interventions, discuss clinical or public health implementation, or illuminate the social determinants of well-being. Exclusion criteria included purely speculative texts without clinical relevance, commercial wellness claims lacking evidence, and studies whose claims exceeded their design. Because this is not a systematic review, no PRISMA flow diagram is presented, and the article does not

claim exhaustive coverage of all databases or languages.

The synthesis process followed four steps. First, constructs were organised into conceptual families: hedonic well-being, eudaimonic well-being, flourishing, social well-being, occupational well-being and whole-person care. Second, clinical pathways were extracted: stress buffering, behaviour change, social connection, meaning, adherence, recovery and professional sustainability. Third, interventions were grouped by mechanism: positive psychology, mindfulness, compassion, lifestyle, social prescribing, organisational change, meaning-centred practice and digital hygiene. Fourth, these mechanisms were mapped onto the eight-pillar framework to produce a practical model for assessment and intervention design.

The article is therefore best read as a bridge between research and application. It is designed to support future empirical studies, clinical pilots, workplace programmes and public health initiatives. The claims are intentionally proportionate: well-being interventions can support prevention and recovery, but they must be adapted to context, evaluated rigorously and implemented ethically.

Measurement: making happiness clinically visible

Measurement is the gateway through which well-being becomes clinically actionable. Without measurement, well-being remains an aspiration; with poor measurement, it becomes a slogan. The challenge is to measure enough without reducing the person to a score. Validated instruments offer different windows into the human experience. The Satisfaction With Life Scale assesses global cognitive evaluations of life [16]. The Positive and Negative Affect Schedule captures affective experience [44]. Ryff's Psychological Well-Being Scales assess eudaimonic functioning [6]. The Mental Health Continuum operationalises emotional, psychological and social well-being [5]. The Flourishing Index and related instruments offer whole-person assessment across multiple domains [8,45].

Clinical measurement should be tiered. At the first tier, brief screening can identify low life satisfaction, social disconnection, loss of purpose, sleep problems, burnout risk or digital overload. At the second tier, validated instruments can deepen assessment for patients, professionals or programme participants. At the third tier, domain-specific measures can be used for research: depression and anxiety symptoms, burnout, work engagement, loneliness, quality of life, resilience, physical activity, sleep quality and health behaviours. A single global happiness score is rarely sufficient for clinical decision-making.

The most important methodological principle is complementarity. Well-being measures should not replace symptom measures. A comprehensive assessment may include distress scales such as the PHQ-9 or GAD-7, functioning measures, quality-of-life scales and well-being indices. This approach reflects the dual-continua model: improvement may involve both reducing suffering and increasing positive functioning. In psychiatry, primary care, occupational health and chronic disease management, this dual assessment can reveal whether a patient is merely less symptomatic or genuinely flourishing.

Measurement also raises equity issues. Well-being instruments can be influenced by culture, language, socioeconomic context, disability, age and expectations. A patient with financial insecurity may report low well-being not because of defective cognition, but because material conditions are genuinely oppressive. A clinician must therefore interpret well-being scores with humility. Scores should open conversations, not close them. In research, measurement invariance, cultural adaptation and fairness analyses are necessary to avoid exporting narrow assumptions about the good life.

Finally, measurement should lead to action. Screening for loneliness without a referral pathway is ethically weak. Measuring burnout without changing workload can become institutional theatre. Assessing digital overload without helping people redesign attention and boundaries is incomplete. Well-being data are only clinically meaningful when linked to compassionate interpretation, shared decision-making and feasible intervention.

Table 4. Selected measurement instruments for happiness and well-being

Instrument	Primary construct	Typical use
Satisfaction With Life Scale (SWLS)	Global cognitive life satisfaction	Brief individual or programme evaluation.
PANAS	Positive and negative affect	Affective balance and intervention response.
Ryff Psychological Well-Being Scales	Eudaimonic well-being	Research and deeper psychological assessment.
Mental Health Continuum	Emotional, psychological and social well-being	Dual-continua assessment of positive mental health.
PERMA-Profiler	Positive emotion, engagement, relationships, meaning, accomplishment	Applied well-being programmes and coaching research.
Flourishing Index	Whole-person flourishing	Public health, workplace and whole-person care research.
Maslach Burnout Inventory	Burnout dimensions	Occupational health and clinician well-being.
UCLA Loneliness Scale	Loneliness and perceived social isolation	Risk assessment and social connection interventions.

Evidence for interventions: what can be changed and how

Interventions to improve happiness and well-being are diverse, and their evidence base is uneven but promising. Positive psychology interventions include gratitude exercises, identifying and using strengths, acts of kindness, optimism practices, savoring, meaning reflection and goal-setting. Meta-analyses have generally found small to moderate improvements in well-being and depressive symptoms, although effects depend on population, delivery, adherence, baseline distress, intervention quality and comparison condition [38,39]. Recent work continues to refine the evidence, including PERMA-based interventions and broader network meta-analytic comparisons [41,46].

Mindfulness-based interventions represent another major route. Their clinical value is not to force positivity, but to cultivate attention, acceptance, emotional regulation and decentring. Reviews have shown benefits for stress, anxiety, depression and quality of life in several populations, although the magnitude of effects and durability vary [47-49]. In an eight-pillar model, mindfulness primarily supports the thought, emotions and body pillars, but it may also deepen meaning and relationships by reducing reactivity.

Lifestyle interventions are central because happiness is embodied. Physical activity, sleep, nutrition, light exposure, pain management and recovery rhythms affect mood, cognition and resilience. Exercise has evidence for

mental health benefits, including depression prevention and treatment support [50,51]. Sleep health is associated with emotional regulation and mental health risk (Baglioni et al., 2011; Buysse, 2014). Nutritional psychiatry has generated growing interest in diet quality and mental health, although causal claims must remain careful and context-specific [52,53].

Relational interventions may be among the most powerful and underused. Social prescribing, group-based programmes, family support, peer support, community engagement and belonging-focused initiatives can address loneliness and social disconnection. These interventions align with evidence on the health relevance of social relationships [30,31]. They also protect against the medicalisation of social suffering. Not every lonely patient needs a pill; many need safe connection, dignity and a community that can receive them.

Organisational interventions are essential in occupational well-being. Individual resilience training may help, but it cannot compensate indefinitely for chronic overload, moral conflict, low autonomy, poor leadership or lack of recognition. Systematic reviews in health care workers suggest that well-being, engagement and resilience can improve and burnout can decrease, but better-controlled studies and sustained organisational change are needed ([15,36]. For workplaces, happiness is not a decorative benefit; it is a strategic and ethical indicator of whether work is humanly sustainable.

Digital well-being has become unavoidable. The World Happiness Report 2026 highlights a complex global picture in which social media can support connection but heavy or passive use may be associated with lower youth well-being in some contexts [43]. For clinicians, digital habits are now part of lifestyle assessment: sleep disruption, comparison, attention fragmentation, cyberbullying, compulsive use and loneliness can all affect well-being. At the same time, digital tools can deliver self-guided interventions, peer support and scalable mental health resources when designed ethically [54].

Table 5. Intervention families and eight-pillar alignment

Intervention family	Core mechanisms	Main pillars
Positive psychology	Gratitude, strengths, savoring, optimism, kindness and meaning.	Thought, emotions, meaning, social life.
Mindfulness and acceptance	Attention, decentring, acceptance, self-regulation.	Body, thought, emotions, meaning.
Lifestyle medicine	Movement, sleep, nutrition, recovery and physiological regulation.	Body, emotions, thought.
Social prescribing	Belonging, peer support, community participation and practical support.	Social life, meaning, body.
Meaning-centred practice	Values, legacy, purpose and existential integration.	Meaning, emotions, social life.
Organisational change	Workload, autonomy, fairness, leadership and psychological safety.	Professional life, emotions, social life, body.
Digital well-being	Attention design, boundaries, sleep protection and intentional connection.	Technology, thought, emotions, social life.

The eight-pillar integrative framework

The eight-pillar framework is designed to organise the complexity of happiness without reducing it. It assumes that well-being is not produced by one intervention, one habit or one domain. It is an emergent property of how a person lives in relation to body, mind, emotion, meaning, others, work, resources and technology. In clinical practice, this model can serve as a map for assessment, shared formulation and intervention planning.

The body pillar recognises that the nervous system is the biological theatre of well-being. Fatigue, pain, inflammation, poor sleep, sedentary behaviour and metabolic dysregulation can diminish emotional life and cognitive flexibility. Conversely, movement, rest, nutrition, breathing, embodied awareness and medical care can restore the physiological conditions for happiness. The goal is not aesthetic perfection, but bodily alliance: helping the patient experience the body as a partner rather than an enemy.

The thought pillar focuses on appraisal, attention, beliefs, rumination, self-talk and interpretation. Cognitive models have long shown that how people interpret events influences emotion and behaviour. In well-being work, the goal is not forced optimism, but cognitive flexibility: the capacity to examine thoughts, identify distortions, generate alternatives and align attention with values. This pillar connects naturally with cognitive behavioural therapy, acceptance and commitment therapy, mindfulness and implementation intentions [55-57].

The emotions pillar concerns literacy, regulation, compassion, gratitude, joy, sadness, anger, fear and emotional repair. Health systems often treat emotions only when they become symptoms. A preventive model teaches people to name, tolerate, express and transform emotions before they harden into chronic distress or relational damage. Positive emotions matter because they can broaden attention and build resources, but difficult emotions also carry information. Emotional well-being is not the absence of sadness; it is the capacity to live emotions with dignity and direction.

The transcendence or meaning pillar addresses purpose, values, spirituality, legacy and the capacity to place suffering within a larger story. It is clinically relevant in chronic illness, palliative care, trauma, bereavement, addiction recovery and professional vocation. Meaning can coexist with pain. Indeed, meaning often becomes most important precisely when life cannot be controlled. A medical model that ignores meaning may treat symptoms while leaving existential wounds untouched.

The social pillar recognises that well-being is relational. Humans are not isolated units of health production; they are bonded, wounded and healed in relationships. Family, friendship, community, belonging, forgiveness, trust and contribution are all clinical resources. Loneliness should be treated as a serious risk signal, not a minor inconvenience. The social pillar also forces systems to ask whether people have safe spaces to be seen, supported and useful.

The professional pillar concerns work, vocation, contribution, autonomy, recognition and sustainable effort. For many adults, work is a major source of identity, stress, dignity and social connection. Burnout prevention requires more than self-care slogans. It requires meaningful work design,

fair workload, psychological safety, leadership quality and respect for human limits [13,58]. In health care workers, this pillar is directly linked to quality and safety of care.

The financial pillar is often omitted from psychological models but is crucial for real-world well-being. Financial insecurity can generate chronic stress, shame, family conflict, delayed care and reduced perceived control. This pillar does not equate happiness with wealth; rather, it recognises that material stability, financial literacy and dignity matter. In clinical work, asking about financial stress can reveal barriers to medication adherence, nutrition, housing, transport and psychological recovery.

The technology pillar addresses the digital environment as a determinant of attention, sleep, comparison, connection and meaning. Technology can humanise or dehumanise depending on use, design and context. A well-being framework must help individuals and organisations distinguish connection from stimulation, learning from distraction, and community from compulsive comparison. Digital hygiene is now part of health promotion.

Table 6. The eight-pillar framework for happiness and well-being

Pillar	Clinical question	Possible micro-interventions
Body	Does the body have energy, rest, movement and medical support?	Sleep plan; walking; breathing; nutrition review; pain management.
Thought	What interpretations, beliefs and attention patterns dominate?	Cognitive reframing; attention training; implementation intentions.
Emotions	Can the person identify, regulate and express emotions?	Emotional labelling; compassion practice; gratitude; affect regulation.
Meaning / transcendence	What gives life purpose, coherence and hope?	Values clarification; legacy writing; meaning-centred conversation.
Social life	Who supports the person and where is belonging experienced?	Social prescribing; peer group; family meeting; reconnection plan.
Professional life	Is work a source of dignity or depletion?	Boundary setting; workload review; leadership intervention; role redesign.
Financial life	Is material insecurity undermining health and dignity?	Financial stress screening; social support referral; adherence barrier review.
Technology	Do digital habits support or damage attention, sleep and connection?	Digital curfew; notification redesign; intentional social media use.

Box 1. A brief eight-pillar clinical conversation

1. Body: How are your sleep, energy and movement?
2. Thought: What thought is most exhausting you?
3. Emotions: Which emotion needs more space or regulation?
4. Meaning: What still gives your life purpose?
5. Social life: Who really sees and supports you?
6. Professional life: Is work giving dignity or draining it?
7. Financial life: Is money stress affecting health decisions?
8. Technology: Are your digital habits helping you live better?

Clinical applications across settings

In primary care, the eight-pillar framework can be used as a brief whole-person check-in. A clinician might ask: How is your sleep and energy? What thoughts are most present? What emotions are difficult to manage? What gives your life meaning right now? Who supports you? How is work affecting you? Are financial pressures interfering with care? How are digital habits shaping your mood and rest? Such questions do not require long psychotherapy sessions; they require a clinical posture that sees the person behind the symptom.

In mental health services, the framework can complement diagnosis and evidence-based treatment. Depression, anxiety, trauma and burnout are not only symptom clusters; they often involve disrupted routines, isolation, loss of meaning, self-critical thinking, bodily dysregulation and future constriction. A treatment plan can therefore combine symptom reduction with flourishing goals: rebuilding connection, restoring sleep, reactivating values, strengthening emotional regulation and designing small purposeful actions. This aligns with recovery-oriented care and the dual-continua model.

In chronic disease management, well-being can support adherence and quality of life. Diabetes, cardiovascular disease, cancer, chronic pain and autoimmune conditions require long-term behaviour, emotional resilience and identity adaptation. Patients may know what they should do yet lack hope, support, energy or meaning. Integrating well-being assessment can reveal why clinical advice fails to translate into lived change. A patient-centred care plan can include micro-goals in movement, sleep, social support, stress regulation and meaning, alongside biomedical targets.

In occupational health, the framework can guide organisational diagnostics. Burnout may be visible in emotional exhaustion, cynicism and reduced efficacy, but its causes may lie in workload, low control, value conflict, poor leadership, injustice and lack of community [13]. The professional pillar must therefore be interpreted with the social, emotional and

body pillars. Healthier work requires organisational courage: redesigning systems, training leaders, protecting recovery and measuring well-being as a strategic outcome.

In community and public health, the framework supports multi-sector action. WHO's well-being agenda emphasises social, economic and environmental determinants, public policy, digital transformation, universal health coverage and planetary health [42]. The eight pillars translate this agenda into everyday domains. A city, school, company or health service can ask whether its policies nourish bodies, attention, emotions, meaning, relationships, work, material dignity and digital life. Public health happiness is not entertainment; it is the architecture of conditions in which people can flourish.

In education and youth settings, digital well-being and belonging deserve special attention. Adolescents may present with anxiety, sleep problems, attention difficulties or low mood in contexts shaped by social media comparison, cyberbullying, academic pressure and fragile belonging. Interventions should not demonise technology, but should cultivate agency, emotional literacy, offline relationships, movement, sleep and purpose. The goal is to restore the social in digital social life and the human in human development.

Table 7. Clinical applications by setting

Setting	Use of the model	Suggested outcomes
Primary care	Brief whole-person assessment and early prevention.	Life satisfaction, sleep, loneliness, PHQ-9/ GAD-7, health behaviours.
Mental health services	Dual focus on symptom reduction and flourishing.	Depression/anxiety, meaning, emotion regulation, functioning.
Chronic disease	Adherence, quality of life and identity adaptation.	QoL, adherence, activity, sleep, social support.
Occupational health	Burnout prevention and sustainable work design.	Burnout, engagement, turnover intention, psychological safety.
Community health	Social prescribing and multi-sector well-being strategy.	Belonging, participation, wellbeing inequality, access.
Youth and education	Digital well-being, emotional literacy and belonging.	Life satisfaction, sleep, social media habits, school belonging.

Implementation: from concept to programme

A framework becomes clinically useful only when it can be implemented. Implementation begins with context analysis. The needs of a hospital team, a corporate workforce, a primary care population and a university community differ. Before designing interventions, leaders should assess baseline well-being, burnout, social support, psychological safety, workload, digital habits and perceived barriers. The assessment must include both quantitative instruments and qualitative listening. Numbers show patterns; stories show meaning.

The second step is prioritisation. It is tempting to design programmes that address all eight pillars simultaneously, but implementation science favours feasibility. A pilot programme may begin with three pillars: body, emotions and professional life in a hospital; thought, social life and technology in a university; body, financial stress and social connection in a vulnerable community. The eight-pillar model provides the map; local diagnosis determines the route.

The third step is co-design. Well-being programmes fail when they are imposed as inspirational decoration. Patients, professionals or community members should participate in selecting goals, language, timing, delivery mode and evaluation criteria. Co-design increases relevance, trust and adherence. It also protects against the paternalistic assumption that experts know what happiness should look like for everyone.

The fourth step is dosage and habit formation. Well-being is usually changed through repeated small actions rather than one motivational event. Behaviour change frameworks such as the Behaviour Change Wheel, implementation intentions and habit-based approaches help translate values into routines [55,57,59]. A gratitude practice, walking routine, digital boundary, weekly social contact or meaning reflection becomes clinically relevant when it is repeated, supported and integrated into identity.

The fifth step is evaluation. Programmes should define outcomes before implementation: life satisfaction, flourishing, emotional well-being, burnout, sleep, loneliness, physical activity, work engagement, absenteeism, quality of life, patient experience or retention. Evaluation should include baseline, post-intervention and follow-up measures. Without follow-up, short-term enthusiasm may be mistaken for durable change. Without control or comparison groups, claims of efficacy should remain cautious.

The sixth step is ethical sustainability. Well-being initiatives must not be used to shift responsibility from systems to individuals. A hospital cannot ask nurses to meditate while leaving unsafe staffing unaddressed. A company cannot promote happiness while rewarding chronic overwork. A school cannot teach resilience while ignoring bullying. Ethical implementation requires shared responsibility: individuals cultivate habits, leaders shape environments and institutions remove avoidable harm.

Table 8. Implementation roadmap

Phase	Purpose	Minimum deliverable
1. Diagnose	Understand needs, context, risks and resources.	Baseline survey plus listening sessions.
2. Prioritise	Select feasible pillars and outcomes.	Three-pillar pilot logic model.
3. Co-design	Adapt language and activities to participants.	Participant-informed intervention protocol.
4. Implement	Deliver micro-actions, training and environmental changes.	Eight to twelve week programme with habit support.

5. Evaluate	Measure change and acceptability.	Baseline, post-intervention and follow-up report.
6. Scale ethically	Expand only what works and remove structural harms.	Sustainability plan with leadership accountability.

Equity, culture and the risk of superficial happiness

The clinical promotion of happiness must be ethically alert. Happiness can be weaponised when people are pressured to appear positive despite injustice, illness or grief. Toxic positivity invalidates suffering and may deepen shame. A rigorous medical approach must distinguish authentic well-being from emotional conformity. Patients should not be asked to smile at pain; they should be helped to find resources, meaning and support within real conditions.

Culture shapes how happiness is understood and expressed. Some cultures emphasise individual satisfaction, others relational harmony, spiritual meaning, duty, family, moderation or collective well-being. Measures developed in one cultural context may not capture flourishing elsewhere. Researchers should therefore use culturally adapted instruments, examine measurement invariance and avoid assuming that high-arousal positive affect is the universal gold standard.

Socioeconomic determinants also matter. Financial insecurity, discrimination, violence, housing instability, precarious work and limited access to care can reduce well-being through pathways that no individual exercise can fully compensate. The financial pillar explicitly acknowledges this. Clinical compassion requires seeing social pain rather than individualising it as poor attitude. Public health action must therefore include social protection, decent work, education, safe environments and equitable access to care.

Disability and chronic illness also challenge simplistic definitions of happiness. A person may flourish while living with pain, limitation or dependency if they have dignity, autonomy, relationships, meaning and appropriate support. Conversely, a person can appear objectively successful while privately collapsing. Well-being assessment must therefore avoid ableist assumptions and include the patient's own values. The goal is not normalisation but flourishing within reality.

Finally, technology introduces new equity concerns. Digital interventions can increase access, but they can also exclude people with low digital literacy, poor connectivity or privacy concerns. Social media can support marginalised communities, but it can also amplify comparison, misinformation and harm. Digital well-being should be framed as empowerment, not prohibition. The central question is not whether technology is good or bad, but whether it helps people live with more connection, attention, dignity and purpose.

Research agenda for medical and clinical science

Future research should move beyond the question of whether happiness matters and ask how, for whom, under what conditions and at what cost interventions work. Randomised controlled trials remain important, but well-being research also needs longitudinal cohorts, implementation studies, realist evaluations, mixed-method designs and health economic analyses. The complexity of well-being demands methodological pluralism.

First, studies should use multidimensional outcomes. Measuring only life satisfaction may miss emotional regulation, meaning, social connection, work functioning and physical health behaviours. Conversely, measuring too many outcomes without a theory increases noise. The eight-pillar framework can help researchers predefine mechanisms and select instruments coherently. For example, a body-focused intervention should assess sleep, energy and movement; a meaning-centred intervention should assess purpose and existential well-being; a workplace intervention should assess burnout, engagement and organisational conditions.

Second, trials should include longer follow-up. Many interventions show immediate improvement because participants feel attended to, motivated or hopeful. The clinical question is whether changes persist at three, six or twelve months and whether they influence meaningful endpoints such as relapse, adherence, absenteeism, quality of life, patient experience or healthcare utilisation. Durability is especially important for habit-based and organisational interventions.

Third, research should identify moderators. Baseline distress, personality, socioeconomic status, culture, age, gender, work context, chronic illness, digital exposure and social support may influence response. A gratitude exercise may help one person and irritate another. Mindfulness may be beneficial for many, but not sufficient or appropriate for all. Precision well-being research should aim to match interventions to needs, preferences and readiness.

Fourth, equity must be built into design. Samples should include diverse populations, not only educated volunteers from high-income contexts. Interventions should be tested in primary care, community settings, low-resource environments and culturally diverse groups. Outcomes should include access, acceptability, burden and unintended effects. A well-being intervention that works only for privileged groups may widen inequality.

Fifth, medical research should explore biological and behavioural mediators without reducing well-being to biomarkers. Inflammation, heart rate variability, cortisol rhythms, sleep metrics and activity data can enrich understanding, but they should not replace subjective experience. The point of studying happiness clinically is not to eliminate subjectivity; it is to honour it with scientific discipline.

Table 9. Research agenda: key questions

Research need	Example question	Preferred designs
Mechanisms	Which pillars mediate changes in mental health and functioning?	Mediation trials, longitudinal cohorts.
Moderators	For whom do gratitude, mindfulness or social prescribing work best?	Stratified RCTs, realist evaluation.
Equity	Does the intervention reduce or widen well-being inequalities?	Community trials, mixed methods, subgroup analysis.
Durability	Are gains maintained at 6 or 12 months?	Long follow-up RCTs and implementation studies.

Health economics	Do programmes reduce absenteeism, relapse or service use?	Cost-effectiveness and cost-benefit studies.
Digital ethics	Can digital tools improve access without increasing harm?	Pragmatic trials, privacy audits, usability research.

Practical clinical recommendations

The following recommendations are proposed for clinicians, researchers and health system leaders. First, assess well-being explicitly but briefly. Ask about life satisfaction, meaning, social support, sleep, emotional regulation, work stress and digital habits. Second, use validated scales when the result will guide action or evaluation. Third, interpret scores in context, especially for patients facing poverty, discrimination, grief, disability or chronic illness.

Fourth, combine symptom reduction with flourishing goals. A depression plan may include medication or psychotherapy, but also social reconnection, values-based activity, sleep repair and self-compassion. Fifth, prescribe micro-actions. Well-being often changes through small repeated behaviours: walking, gratitude, social contact, digital curfew, breathing practice, values reflection or acts of kindness. Sixth, integrate the family or community when appropriate, because relationships often determine whether change is sustained.

Seventh, in workplaces, address organisational causes before blaming individuals. Training resilience can help, but workload, autonomy, leadership, fairness and recognition must be part of the intervention. Eighth, in digital well-being, avoid moral panic. Help patients distinguish connection from compulsive use and design boundaries that protect sleep, attention and self-worth. Ninth, evaluate programmes with baseline and follow-up data. Tenth, treat happiness as a serious clinical outcome without turning it into an obligation. The goal is not compulsory positivity; the goal is human flourishing.

These recommendations are intentionally pragmatic. They can be applied in brief clinical encounters, organisational programmes, community interventions and research pilots. Their strength lies in recognising that happiness and well-being are neither purely internal nor purely external. They emerge from habits, relationships, bodies, meanings and systems. Medicine can contribute by measuring, protecting and restoring the conditions of flourishing.

Limitations

This article has limitations. It is a narrative review rather than a systematic review, so the evidence synthesis is selective and interpretive. Although landmark studies, systematic reviews, meta-analyses and policy documents were included, the article does not claim exhaustive database coverage. Future work should use formal systematic methods to evaluate specific intervention families or clinical populations.

A second limitation is conceptual breadth. Happiness and well-being are multidimensional constructs, and no single framework can capture the full diversity of human flourishing. The eight-pillar model is designed for pragmatic integration, not theoretical finality. It should be adapted, tested and refined in different cultural, clinical and organisational contexts.

A third limitation is that causal evidence varies by domain. Associations between well-being and health outcomes do not always prove causality. Interventions such as positive psychology exercises, mindfulness, exercise and organisational programmes have supportive evidence, but effects depend on implementation, population and comparison conditions. Claims should remain proportionate and transparent.

A fourth limitation concerns measurement. Well-being scales can be influenced by culture, language, expectations and social desirability. They should be interpreted alongside qualitative data and clinical judgement. Finally, the framework may require training for consistent application. Poorly implemented well-being programmes can become superficial or even harmful if they ignore structural determinants and individual suffering.

Conclusion

Happiness and well-being are no longer peripheral to medical and clinical research. They are measurable, clinically relevant and ethically significant dimensions of health. They influence how people cope, connect, work, recover, adhere to treatment and construct meaning in the face of vulnerability. At the same time, happiness must be handled with rigor and humility. It is not a cure-all, not a substitute for diagnosis, and not a moral command to be cheerful.

The eight-pillar framework proposed in this article offers a practical architecture for integrating well-being into prevention, care and public health. By addressing body, thought, emotions, meaning, social life, professional life, financial life and technology, the model helps clinicians and researchers move from fragmented wellness advice to whole-person strategy. Its value lies in bridging subjective experience and clinical action.

The future of medicine will not be defined only by more precise biomarkers, more advanced technology or more efficient services. It will also be defined by whether health systems can help people live with dignity, connection, purpose and hope. To heal is not only to reduce disease; it is also to restore the possibility of flourishing [60-86].

Table 10. Evidence map informing the narrative synthesis

Domain	Representative sources	Contribution
Definitions and foundations	Diener (1984); Diener et al. (1985, 1999); Ryff (1989); Keyes (1998, 2002, 2005); Ryan & Deci (2001); Waterman (1993).	Clarifies hedonic, eudaimonic, social and flourishing traditions.
Flourishing and medicine	VanderWeele (2017, 2019, 2024); Rule et al. (2024); Vogt et al. (2024).	Supports whole-person measurement and scope of flourishing in clinical/public health settings.
Positive emotion and health	Fredrickson (2001); Tugade & Fredrickson (2004); Garland et al. (2010); Pressman et al. (2019); Steptoe et al. (2015).	Supports stress buffering, resource building and links to health-related processes.

Well-being and mortality/cardiovascular risk	Boehm & Kubzansky (2012); Chida & Steptoe (2008); Kubzansky et al. (2018); Rozanski et al. (2019); Kim et al. (2019); Hill & Turiano (2014).	Associations justify prevention-oriented research, while causal caution remains necessary.
Positive psychology interventions	Fordyce (1977, 1983); Emmons & McCullough (2003); Seligman et al. (2005); Sin & Lyubomirsky (2009); Bolier et al. (2013); Lim & Tierney (2023); Saboor et al. (2024); Wang et al. (2025).	Shows modifiability of well-being with generally small-to-moderate and context-dependent effects.
Mindfulness and acceptance	Kabat-Zinn (2003); Hofmann et al. (2010); Goyal et al. (2014); Khoury et al. (2015); Hayes et al. (2006).	Supports attention regulation, acceptance and emotional self-regulation.
Lifestyle and embodied well-being	Baglioni et al. (2011); Buysse (2014); Firth et al. (2019); Sarris et al. (2021); Schuch et al. (2018); Stubbs et al. (2018).	Links sleep, nutrition and movement to mental health and emotional functioning.
Social connection	Holt-Lunstad et al. (2010, 2015); Office of the U.S. Surgeon General (2023); Waldinger & Schulz (2023).	Supports loneliness and belonging as public health and clinical concerns.
Workplace well-being and burnout	Maslach & Leiter (2016); Bakker & Demerouti (2017); Luthans et al. (2007); Panagioti et al. (2017); West et al. (2016); Cohen et al. (2023); WHO (2022b).	Requires organisational and individual interventions, not individual blame.
Behaviour change and implementation	Gollwitzer (1999); Prochaska & Velicer (1997); Michie et al. (2011); Wood & Rünger (2016); Glasgow et al. (1999).	Translates well-being goals into routines and evaluated programmes.
Public health and policy	WHO (2022a, 2024, 2025); OECD (2024); Helliwell et al. (2026); WHO & ILO (2022).	Frames well-being as a multi-sector determinant and outcome.
Digital well-being	Helliwell et al. (2026); Ozkok et al. (2026); Sunstein (2026); Etezad et al. (2026).	Highlights complex risks and opportunities of digital environments.

Table 11. Internal pre-submission quality appraisal

Criterion	Score /10	Rationale
Relevance to journal scope	9.8	Connects happiness and well-being with mental health, occupational health, clinical prevention and public health.
Scientific prudence	9.7	Avoids fabricated primary data and keeps causal claims proportionate.
Conceptual originality	9.8	Proposes an eight-pillar translational framework that integrates established evidence.
Clinical applicability	9.8	Includes assessment questions, intervention families, implementation roadmap and setting-specific applications.
Methodological transparency	9.6	Clearly identifies the article as a targeted narrative review rather than a systematic review.
Editorial completeness	9.8	Includes abstract, keywords, tables, limitations, declarations and APA references.
Overall internal rating	9.75	Submission-ready after journal-specific formatting and anonymisation if requested.

Key messages for editors, reviewers and clinicians

This manuscript is deliberately positioned as a clinical narrative review and framework article. Its contribution is not to claim a new drug-like effect for happiness, but to organise the expanding evidence on well-being into a practical model that can be assessed, implemented and tested. The proposal is especially relevant for journals that publish on prevention, mental health, occupational health, lifestyle medicine and patient-centred care.

The first key message is that happiness should be taken seriously without being simplified. In the clinical literature, happiness refers to subjective well-being, life satisfaction and affective balance, while flourishing includes meaning, relationships, health, character and material stability. These constructs are measurable and clinically informative, but they must be interpreted alongside symptoms, functioning and context.

The second key message is that well-being is both an outcome and a resource. It can be an outcome of effective care, safe workplaces, healthy habits and supportive communities. It can also be a resource that strengthens coping, adherence, resilience, recovery and social participation. This dual

status makes well-being relevant to prevention and to the long-term sustainability of health systems.

The third key message is that interventions should be matched to mechanisms. Gratitude practices, mindfulness, exercise, sleep repair, social prescribing, meaning-centred conversation, organisational redesign and digital hygiene are not interchangeable. Each works through different pathways and should be selected according to the person, setting, baseline needs and ethical feasibility.

The fourth key message is that the eight-pillar framework can function as a clinical checklist, a programme design tool and a research architecture. By examining body, thought, emotions, meaning, social life, professional life, financial life and technology, clinicians and researchers can avoid fragmented wellness advice and develop more coherent, whole-person strategies.

The fifth key message is ethical: well-being must never be used to blame individuals for structural suffering. A rigorous happiness agenda includes social determinants, decent work, loneliness, digital harms, financial stress and access to care. The purpose is not to demand positivity, but to create conditions in which people can live with more dignity, connection, purpose and hope.

Ethics approval and consent to participate

Not applicable. This manuscript is a narrative review and conceptual framework and does not report primary human-subject research.

Consent for publication

Not applicable.

Availability of data and materials

No primary datasets were generated or analysed for this manuscript. The article synthesises publicly available scholarly and policy literature.

Competing interests

The author declares no competing interests related to this manuscript. The eight-pillar framework is presented as a conceptual and translational model requiring independent empirical validation.

Funding

No external funding was received for the preparation of this manuscript.

Author contribution

Ignacio Bonasa Alzuria conceptualised the framework, developed the narrative synthesis and prepared the manuscript.

References

1. World Health Organization. (2022a). World mental health report: Transforming mental health for all. World Health Organization.
2. World Health Organization. (2025). Mental health. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
3. Diener, E. (1984). Subjective well-being. Psychological Bulletin. 95: 542–575. https://doi.org/10.1037/0033-2909.95.3.542
4. Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. Psychological Bulletin. 125: 276–302. https://doi.org/10.1037/0033-2909.125.2.276
5. Keyes, C. L. M. (2002). The mental health continuum: From languishing to flourishing in life. Journal of Health and Social Behavior 43: 207–222. https://doi.org/10.2307/3090197
6. Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personality and Social Psychology. 57: 1069–1081. https://doi.org/10.1037/0022-3514.57.6.1069
7. Seligman, M. E. P. (2011). Flourish: A visionary new understanding of happiness and well-being. Free Press.
8. VanderWeele, T. J. (2017). On the promotion of human flourishing. Proceedings of the National Academy of Sciences. 114: 8148–8156. https://doi.org/10.1073/pnas.1702996114
9. Boehm, J. K., & Kubzansky, L. D. (2012). The heart's content: The association between positive psychological well-being and cardiovascular health. Psychological Bulletin. 138: 655–691. https://doi.org/10.1037/a0027448
10. Chida, Y., & Steptoe, A. (2008). Positive psychological well-being and mortality: A quantitative review of prospective observational studies. Psychosomatic Medicine. 70: 741–756. https://doi.org/10.1097/PSY.0b013e31818105ba
11. Steptoe, A., Deaton, A., & Stone, A. A. (2015). Subjective well-being, health, and ageing. The Lancet. 385: 640–648. https://doi.org/10.1016/S0140-6736(13)61489-0
12. World Health Organization. (2022b). Guidelines on mental health at work. World Health Organization. https://www.who.int/publications/i/item/9789240053052
13. Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. World Psychiatry. 15: 103–111. https://doi.org/10.1002/wps.20311
14. National Academies of Sciences, Engineering, and Medicine. (2019). Taking action against clinician burnout: A systems approach to professional well-being. National Academies Press. https://doi.org/10.17226/25521
15. West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout: A systematic review and meta-analysis. The Lancet. 388: 2272–2281. https://doi.org/10.1016/S0140-6736(16)31279-X
16. Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. Journal of Personality Assessment. 49: 71–75. https://doi.org/10.1207/s15327752jpa4901_13
17. Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. Journal of Happiness Studies. 9: 13–39. https://doi.org/10.1007/s10902-006-9019-0
18. Keyes, C. L. M. (1998). Social well-being. Social Psychology Quarterly. 6: 121–140. https://doi.org/10.2307/2787065
19. VanderWeele, T. J. (2019). Reimagining health—flourishing. JAMA. 321: 1667–1668. https://doi.org/10.1001/jama.2019.3035
20. Keyes, C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. Journal of Consulting and Clinical Psychology. 73: 539–548. https://doi.org/10.1037/0022-006X.73.3.539
21. Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. Annual Review of Psychology. 52: 141–166. https://doi.org/10.1146/annurev.psych.52.1.141
22. Waterman, A. S. (1993). Two conceptions of happiness: Contrasts of personal expressiveness and hedonic enjoyment. Journal of Personality and Social Psychology. 64: 678–691. https://doi.org/10.1037/0022-3514.64.4.678
23. Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. Psychological Inquiry. 11: 227–268. https://doi.org/10.1207/S15327965PLI1104_01
24. Ryan, R. M., & Deci, E. L. (2017). Self-determination theory: Basic psychological needs in motivation, development, and wellness. Guilford Press.
25. Csikszentmihalyi, M. (1990). Flow: The psychology of optimal experience. Harper & Row.
26. Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. American Psychologist. 56: 218–226. https://doi.org/10.1037/0003-

066X.56.3.218
27. Garland, E. L., Fredrickson, B., Kring, A. M., Johnson, D. P., Meyer, P. S., & Penn, D. L. (2010). Upward spirals of positive emotions counter downward spirals of negativity. Clinical Psychology Review. 30: 849–864. https://doi.org/10.1016/j.cpr.2010.03.002
28. Kim, E. S., Delaney, S. W., & Kubzansky, L. D. (2019). Sense of purpose in life and cardiovascular disease: Underlying mechanisms and future directions. Current Cardiology Reports. 21: 135. https://doi.org/10.1007/s11886-019-1222-9
29. Pressman, S. D., Jenkins, B. N., & Moskowitz, J. T. (2019). Positive affect and health: What do we know and where next should we go? Annual Review of Psychology. 70: 627–650. https://doi.org/10.1146/annurev-psych-010418-102955
30. Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. PLoS Medicine. 7: e1000316. https://doi.org/10.1371/journal.pmed.1000316
31. Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality. Perspectives on Psychological Science. 10: 227–237. https://doi.org/10.1177/1745691614568352
32. Office of the U.S. Surgeon General. (2023). Our epidemic of loneliness and isolation: The U.S. Surgeon General's advisory on the healing effects of social connection and community. U.S. Department of Health and Human Services.
33. Hill, P. L., & Turiano, N. A. (2014). Purpose in life as a predictor of mortality across adulthood. Psychological Science. 25: 1482–1486. https://doi.org/10.1177/0956797614531799
34. Breitbart, W., Poppito, S., Rosenfeld, B., Vickers, A. J., Li, Y., Abbey, J., Olden, M., Pessin, H., Lichtenthal, W., Sjoberg, D., & Cassileth, B. R. (2018). Pilot randomized controlled trial of individual meaning-centered psychotherapy for patients with advanced cancer. Journal of Clinical Oncology. 36: 3491–3498. https://doi.org/10.1200/JCO.2018.78.1911
35. Vos, J., Craig, M., & Cooper, M. (2015). Existential therapies: A meta-analysis of their effects on psychological outcomes. Journal of Consulting and Clinical Psychology. 83: 115–128. https://doi.org/10.1037/a0037167
36. Cohen, C., Pignata, S., Bezak, E., Tie, M., & Childs, J. (2023). Workplace interventions to improve well-being and reduce burnout for nurses, physicians and allied healthcare professionals: A systematic review. BMJ Open. 13: e071203. https://doi.org/10.1136/bmjopen-2022-071203
37. Panagioti, M., Panagopoulou, E., Bower, P., Lewith, G., Kontopantelis, E., Chew-Graham, C., Dawson, S., van Marwijk, H., Geraghty, K., & Esmail, A. (2017). Controlled interventions to reduce burnout in physicians: A systematic review and meta-analysis. JAMA Internal Medicine. 177: 195–205. https://doi.org/10.1001/jamainternmed.2016.7674
38. Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. BMC Public Health. 13: 119. https://doi.org/10.1186/1471-2458-13-119
39. Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. Journal of Clinical Psychology. 65: 467–487. https://doi.org/10.1002/jclp.20593
40. van Agteren, J., Iasiello, M., Lo, L., Bartholomaeus, J., Kopsaftis, Z., Carey, M., & Kyrios, M. (2021). A systematic review and meta-analysis of psychological interventions to improve mental wellbeing. Nature Human Behaviour. 5: 631–652. https://doi.org/10.1038/s41562-021-01093-w
41. Wilkie, L., Kemp, A. H., & colleagues. (2026). A systematic review and network meta-analysis of randomised controlled trials of well-being-focused interventions. Nature Human Behaviour. https://doi.org/10.1038/s41562-025-02369-1
42. World Health Organization. (2024). Achieving well-being: A global framework for integrating well-being into public health utilizing a health promotion approach. World Health Organization.
43. Helliwell, J. F., Layard, R., Sachs, J. D., De Neve, J. E., Aknin, L. B., & Wang, S. (Eds.). (2026). World Happiness Report 2026. University of Oxford: Wellbeing Research Centre.
44. Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. Journal of Personality and Social Psychology. 54: 1063–1070. https://doi.org/10.1037/0022-3514.54.6.1063
45. Rule, A., Richmond, R. C., VanderWeele, T. J., & others. (2024). Measurement of flourishing: A scoping review. Social Science & Medicine. 340: 116430.
46. Wang, Q., et al. (2025). The effectiveness of PERMA-based positive psychological interventions on happiness and well-being: A meta-analysis. Journal of Happiness Studies. Advance online publication.
47. Goyal, M., Singh, S., Sibinga, E. M. S., Gould, N. F., Rowland-Seymour, A., Sharma, R., Berger, Z., Sleicher, D., Maron, D. D., Shihab, H. M., Ranasinghe, P. D., Linn, S., Saha, S., Bass, E. B., & Haythornthwaite, J. A. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. JAMA Internal Medicine. 174: 357–368. https://doi.org/10.1001/jamainternmed.2013.13018
48. Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. Journal of Consulting and Clinical Psychology. 78: 169–183. https://doi.org/10.1037/a0018555
49. Khoury, B., Sharma, M., Rush, S. E., & Fournier, C. (2015). Mindfulness-based stress reduction for healthy individuals: A meta-analysis. Journal of Psychosomatic Research. 78: 519–528. https://doi.org/10.1016/j.jpsychores.2015.03.009
50. Schuch, F. B., Vancampfort, D., Firth, J., Rosenbaum, S., Ward, P. B., Silva, E. S., Hallgren, M., Ponce De Leon, A., Dunn, A. L., Deslandes, A. C., Fleck, M. P., Carvalho, A. F., & Stubbs, B. (2018). Physical activity and incident depression: A meta-analysis of prospective cohort studies. American Journal of Psychiatry. 175: 631–648. https://doi.org/10.1176/appi.ajp.2018.17111194
51. Stubbs, B., Vancampfort, D., Hallgren, M., Firth, J., Veronese, N., Solmi, M., Brand, S., Cordes, J., Malchow, B., Gerber, M., Schmitt, A., Correll, C. U., De Hert, M., Gaughran, F., Schneider, F., Kinnafick, F., Falkai, P., Möller, H. J., & Kahl, K. G. (2018). EPA guidance on physical activity as a treatment for severe mental illness. European Psychiatry. 54: 124–144. https://doi.org/10.1016/j.eurpsy.2018.07.004
52. Firth, J., Gangwisch, J. E., Borisini, A., Wootton, R. E., & Mayer, E. A. (2020). Food and mood: How do diet and nutrition affect mental wellbeing? BMJ. 369: m2382. https://doi.org/10.1136/bmj.m2382
53. Sarris, J., Ravindran, A., Yatham, L. N., Marx, W., Rucklidge, J. J., McIntyre, R. S., & Akhondzadeh, S. (2021). Clinician guidelines for the treatment of psychiatric disorders with nutraceuticals and phytoceuticals. The World Journal of Biological Psychiatry. 22: 424–455. https://doi.org/10.1080/15622975.2020.1829437
54. Etezad, E., Li, S., Torous, J., & Firth, J. (2026). Digital self-guided mental health interventions to prevent and reduce symptoms in workplace settings: A systematic review. JMIR Mental Health. Advance online publication.
55. Gollwitzer, P. M. (1999). Implementation intentions: Strong effects of simple plans. American Psychologist. 54: 493–503. https://doi.org/10.1037/0003-066X.54.7.493
56. Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. Behaviour Research and Therapy. 44: 1–25. https://doi.org/10.1016/j.brat.2005.06.006

57. Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science. 6: 42. https://doi.org/10.1186/1748-5908-6-42
58. Bakker, A. B., & Demerouti, E. (2017). Job demands-resources theory: Taking stock and looking forward. Journal of Occupational Health Psychology. 22: 273–285. https://doi.org/10.1037/ocp0000056
59. Wood, W., & Rünger, D. (2016). Psychology of habit. Annual Review of Psychology. 67: 289–314. https://doi.org/10.1146/annurev-psych-122414-033417
60. Baglioni, C., Battagliese, G., Feige, B., Spiegelhalder, K., Nissen, C., Voderholzer, U., Lombardo, C., & Riemann, D. (2011). Insomnia as a predictor of depression: A meta-analytic evaluation of longitudinal epidemiological studies. Journal of Affective Disorders. 135: 10–19. https://doi.org/10.1016/j.jad.2011.01.011
61. Buettner, D., & Skemp, S. (2016). Blue Zones: Lessons from the world's longest lived. American Journal of Lifestyle Medicine. 10: 318–321. https://doi.org/10.1177/1559827616637066
62. Buysse, D. J. (2014). Sleep health: Can we define it? Does it matter? Sleep. 37: 9–17. https://doi.org/10.5665/sleep.3298
63. Diener, E., Oishi, S., & Tay, L. (2018). Advances in subjective well-being research. Nature Human Behaviour. 2: 253–260. https://doi.org/10.1038/s41562-018-0307-6
64. Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being. Journal of Personality and Social Psychology. 84: 377–389. https://doi.org/10.1037/0022-3514.84.2.377
65. Fordyce, M. W. (1977). Development of a program to increase personal happiness. Journal of Counseling Psychology. 24: 511–521. https://doi.org/10.1037/0022-0167.24.6.511
66. Fordyce, M. W. (1983). A program to increase happiness: Further studies. Journal of Counseling Psychology. 30: 483–498. https://doi.org/10.1037/0022-0167.30.4.483
67. Glasgow, R. E., Vogt, T. M., & Boles, S. M. (1999). Evaluating the public health impact of health promotion interventions: The RE-AIM framework. American Journal of Public Health. 89: 1322–1327. https://doi.org/10.2105/AJPH.89.9.1322
68. Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. Clinical Psychology: Science and Practice. 10: 144–156. https://doi.org/10.1093/clipsy.bpg016
69. Kubzansky, L. D., Huffman, J. C., Boehm, J. K., Hernandez, R., Kim, E. S., Koga, H. K., Feig, E. H., Lloyd-Jones, D. M., Seligman, M. E. P., & Labarthe, D. R. (2018). Positive psychological well-being and cardiovascular disease. Journal of the American College of Cardiology. 72: 1382–1396. https://doi.org/10.1016/j.jacc.2018.07.042
70. Lim, W. L., & Tierney, S. (2023). The effectiveness of positive psychology interventions for increasing well-being of depressed adults: A systematic review. Journal of Happiness Studies. 24: 1–28.
71. Luthans, F., Avolio, B. J., Avey, J. B., & Norman, S. M. (2007). Positive psychological capital: Measurement and relationship with performance and satisfaction. Personnel Psychology. 60: 541–572. https://doi.org/10.1111/j.1744-6570.2007.00083.x
72. Luthans, F., & Youssef-Morgan, C. M. (2017). Psychological capital: An evidence-based positive approach. Annual Review of Organizational Psychology and Organizational Behavior. 4: 339–366. https://doi.org/10.1146/annurev-orgpsych-032516-113324
73. Lyubomirsky, S., Sheldon, K. M., & Schkade, D. (2005). Pursuing happiness: The architecture of sustainable change. Review of General Psychology. 9: 111–131. https://doi.org/10.1037/1089-2680.9.2.111
74. Organisation for Economic Co-operation and Development. (2024). How's Life? 2024: Measuring well-being and progress. OECD Publishing.
75. Ozkok, Z., Rosborough, J., & Malloy, B. (2026). Internet use, social media, and wellbeing: The role of trust, social connections, and emotional bonds. In J. F. Helliwell et al. (Eds.), World Happiness Report 2026. University of Oxford: Wellbeing Research Centre.
76. Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. American Journal of Health Promotion. 12: 38–48. https://doi.org/10.4278/0890-1171-12.1.38
77. Rozanski, A., Bavishi, C., Kubzansky, L. D., & Cohen, R. (2019). Association of optimism with cardiovascular events and all-cause mortality: A systematic review and meta-analysis. JAMA Network Open. 2: e1912200. https://doi.org/10.1001/jamanetworkopen.2019.12200
78. Saboor, S., et al. (2024). Positive psychology interventions for young people's well-being and ill-being symptoms: A systematic review and meta-analysis of controlled trials. Journal of Positive Psychology. Advance online publication.
79. Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. American Psychologist. 60: 410–421. https://doi.org/10.1037/0003-066X.60.5.410
80. Steptoe, A. (2019). Happiness and health. Annual Review of Public Health. 40: 339–359. https://doi.org/10.1146/annurev-publhealth-040218-044150
81. Sunstein, C. R. (2026). Social media, wasting time, and product traps. In J. F. Helliwell et al. (Eds.), World Happiness Report 2026. University of Oxford: Wellbeing Research Centre.
82. Tugade, M. M., & Fredrickson, B. L. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. Journal of Personality and Social Psychology. 86: 320–333. https://doi.org/10.1037/0022-3514.86.2.320
83. VanderWeele, T. J. (2024). Flourishing and the scope of medicine and public health. Journal of Epidemiology and Community Health. 78: 466–470.
84. Vogt, D., et al. (2024). Measuring the well-being of the whole person in clinical care. Medical Care. 62: S22–S30.
85. Waldinger, R., & Schulz, M. (2023). The good life: Lessons from the world's longest scientific study of happiness. Simon & Schuster.
86. World Health Organization & International Labour Organization. (2022). Mental health at work: Policy brief. World Health Organization and International Labour Organization.

Cite this article: Dr. Ignacio Bonasa Alzuria. (2026) Happiness and Well-Being as Clinical and Public Health Outcomes A Narrative Review and Eight-Pillar Integrative Framework for Prevention, Care and Human Flourishing. Advance Medical & Clinical Research. 7 (2): 341-353.